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17 MAY 2010

TO: VCSA
CC: CHIEF OF STAFF OF THE ARMY

FROM: Gen (ret) Fred Franks

SUBJECT: TOP 8 ISSUES as of 14 May 2010

The purpose of this memo is to provide you our top issues as of this date as you requested.

Our overarching strategy conclusion remains that given the pace of use of RC as an operational reserve and increased use of health assessment tools, the pace of growth of not medically ready RC Soldiers and their access to the Disability System has far outpaced our current system's ability to handle the growth.

Currently there are eight top areas to correct that overarching strategic trend. The solutions lie in one of our four tactical lines of operations (TLO): Command emphasis; training and education; policy to include resources; and process. These areas are indicated in parentheses following each listed issue.

We do not have any resource requirements listed. In our previous work last year, General Casey instructed us not to do that as the Army could handle putting a resource bill on proposals. I assumed the same guidance for this work.

MAJOR ISSUES.

1. Current Army resources (administrative, medical providers, PEBLOs, case managers, etc.) appear to be insufficient to medically sustain the Reserve Components in an operational environment. The current manifestation of this is the inability of the Reserve Components to manage the rapid increase of P3/4 profiles which has risen from 22,000 in 2008 to over 35,000 today, due to the inception of the PHA in 2008 and the increased operational tempo since 2003. (TLO: Policy -resources and Process)

2. Current MEB/PEB access standards at MTF are different for AC and non-WTU RC Soldiers, perhaps caused by lack of resources, but resulting in restrictions being placed on the numbers of RC cases taken on by the PEBLO. The Army does not seem to follow policies and regulations consistently. This disparity results in inequity in processing RC Soldiers through the MEB/PEB by delaying their entry into the process and/or extending the duration of the board unnecessarily. (TLO: Command Emphasis, Policy-resources and Process)

3. Current limited access for 'In LOD' evaluation and treatment within the Military Healthcare System (MTF) causes RC Soldiers to have to utilize other healthcare resources, to include TRICARE, often at their own expense without pay and allowances or travel authorized. This also causes difficulty with proper documentation and follow up normally available in the Military Healthcare System. This places a great burden upon the Soldier and their Family members and can contribute greatly to delays in continuing care and military classification processing to include access to the Disability System due

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to lack of coordinated information flow at the MTF. (TLO: Command Emphasis, Education and Training and Policy -resources)

4. There is a lack of continuity of medical information throughout the RC Soldiers' continuum of service. Current policy and infrastructure lead to medical information stored in a variety of military, VA and civilian medical and administrative data systems that do not have shared access across the Enterprise. This prevents command visibility and oversight and contributes to significant delays in treatment and medical readiness. (TLO- Policy-resources and Process)

5. There is an absence of transition processes and services for the RC Soldier found unfit by the PEB as they separate from the Army. This lack of support adversely affects successful utilization of all benefits and seamless reintegration back into their communities. (TLO: Education and Training, Policy-resources)

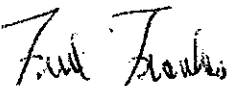
6. The Army created Incapacitation Pay to support Soldiers in a Strategic Reserve who were injured during military duties and unable to do their civilian jobs. The Army needs to establish a comparable program to support Soldiers in an Operational Reserve who were injured during contingency operations. (TLO: Policy-resources)

7. There is great disparity between Active and Reserve Line of Duty policies and practices. Current processes place the 'burden of proof' on the RC Soldier as opposed to an 'assumption of in line of duty' for the Active Component Soldier to receive appropriate medical evaluation and treatment. Utilization of the Reserve Components in an operational environment requires these Soldiers to live an 'Army lifestyle' to meet all requirements to be in the Army. (TLO: Process, Policy-resources)

8. There are multiple obstacles and disincentives to include stabilization time for reintegration that exist preventing Reserve Component Soldiers from reporting and RC from assessing medical issues which become manifest after release from Army duty. Current practices for stabilization in AC following redeployment are being reworked, making such a relook also relevant for RC. In addition, current law (Title 10: 12301H) allows for orders to be processed bringing Reserve Component Soldiers on active duty for evaluation and treatment as well as processing through medical boards. Current Army policy and practices do not appear to fully support implementation of this law. (TLO: Command Emphasis, Training and Education, Policy-resources).

Thank you for the continuing opportunity to do this noble work in support of our Army and Reserve Component Soldiers and their Families. We remain committed to finding solutions to these issues.

Very Respectfully,



Frederick M. Franks, Jr.
General, US Army (ret)